DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular
No. 40-8

1 October 2003

Expires 1 October 2005

Medical Services

DIABETES OUTPATIENT FORMS

1. HISTORY. This issue publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

2. PURPOSE.

a. This circular provides policy and implementing instructions for the diabetes outpatient forms prescribed by this circular: U.S. Army Medical Command (MEDCOM) Form 705-R (Diabetes Visit), MEDCOM Form 706-R (Diabetes Flow Sheet), and MEDCOM Form 724-R (Diabetes Action Plan).

b. These forms will facilitate outpatient treatment record (OTR) documentation by cueing practitioners to document key aspects in their assessment and treatment of patients with diabetes. A panel of expert consultants from the Army, Navy, Air Force, and Department of Veterans Affairs (VA) identified key aspects of care based on scientific evidence. These facts were then converted into the Department of Defense/VA Practice Guideline on the treatment of patients with diabetes. Key aspects were then transformed onto the forms named in paragraph a above and prescribed by this circular.

3. APPLICABILITY. This circular applies to all MEDCOM facilities that have been granted an exception to policy for use of the test forms (prescribed herein) to document care of patients with diabetes.

4. REFERENCES. AR 40-66, Medical Record Administration and Health Care Documentation, provides guidance on medical record documentation and is applicable.

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*This circular supersedes MEDCOM Circular 40-8, 1 October 2001.

5. EXPLANATION OF ABBREVIATIONS AND TERMS.

a. Abbreviations.

MEDCOM . . . U.S. Army Medical Command
OTR. . . . . outpatient treatment record
SF . . . . . standard form
VA . . . . . Department of Veterans Affairs

b. Terms. See AR 40-66.

6. RESPONSIBILITIES. See AR 40-66.

7. POLICY.

a. Personnel in military treatment facilities may use MEDCOM Forms 705-R, 706-R, and 724-R for the period of the test (through 1 October 2005) or as directed by the MEDCOM.

b. The MEDCOM test forms prescribed by this circular will be filed in the OTR with the standard form (SF) 600 (Health Record-Chronological Record of Medical Care) in reverse chronological order (most recent on top). MEDCOM Form 706-R will be filed in the OTR on the left-hand side of the record under DA Form 5571 (Master Problem List), if it exists.

c. MEDCOM Form 705-R may be used in lieu of the SF 600 to document treatment only for patients with diabetes being treated on an outpatient basis.

d. MEDCOM Form 724-R can be copied with one given to the patient and one in the medical record.

e. All current requirements of AR 40-66, other than those addressed in this circular, remain in effect.

8. INSTRUCTIONS FOR USE OF THE DIABETES OUTPATIENT FORMS. Note: All forms are authorized for local reproduction (that is, "R" forms) and are contained in appendix A of this circular. All forms are to be printed head to foot, except MEDCOM Form 706-R which is only one page.

a. MEDCOM Form 705-R (Diabetes Visit).

(1) Purpose. This form may be used to document the first clinic visit of patients with "new onset" diabetes or return visits of patients with diabetes.

(2) Preparation. This form has three sections. Section I, Vital Signs, is to be completed by health care personnel. Section II, Patient Demographics (Subjective), is to be completed by the patient. Section III, Medical History, Assessment, Diagnosis, and Treatment, is to be completed by the health care provider. This section also contains areas for referrals and follow-up appointments.

(3) Content. Section I includes documentation of height, weight, and vital signs. Section II includes demographic, diabetic symptoms, and current medication history. Section III includes check box and free-hand areas for documentation of the patient's medical history, physical assessment, diagnosis, treatment plan, referrals, and follow-up appointments.

b. MEDCOM Form 706-R (Diabetes Flow Sheet).

(1) Purpose. This form may be used by any provider to document all significant inpatient and outpatient visits and therapeutic intervention events in the management of the patient with diabetes. It will provide a quick overview of the patient's diabetes history to all providers, eliminating the need to page through the chart in order to "piece" a history together.

(2) Preparation. This form is to be initiated on the first diabetes visit and then updated at every subsequent visit by the health care provider.

(3) Content. Items 1 through 3 of this one-page form provide space for documentation of the following: name of the primary provider, name of the case manager, diagnosis with associated secondary diagnosis, and date of diabetes education. Item 4 provides space for annotation of specific monitored items; these spaces are filled in at 3-month and yearly intervals. Items 5 and 6 provide spaces for annotation of specialty referrals and special primary care considerations.

c. MEDCOM Form 724-R (Diabetes Action Plan).

(1) Purpose. This form may be used to document diabetes self-management goals in the first clinic visit of a patient with "new" onset diabetes or return visits of patients with diabetes.

(2) Preparation. This form has two sections and a diabetes self-management action plan. Section I, My Diabetes Self-Management Goals, Medication List and My Personal Best, is to be completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. Section II, My Diabetes Self-Management Follow-Up Plan, is to be completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. The Diabetes Self-Management Action Plan is to be reviewed and completed by the patient and reviewed by the Primary Care Provider or Diabetes Educator/Case Manager. The patient and provider date and sign the front and back of the form.

(3) Content. Section I includes documentation of Diabetes Self-Management Goals in which the patient selects and initials at least three goals from the list. The Medication List includes a place to record diabetes medications. My Personal Best includes BMI, Blood Pressure, HbA1c, LDL, Urine Protein, Monitors For, Acceptable Range, My Range, and Goal for Next Visit. Section II includes eye exam, foot assessment, annual flu vaccine, pneumonia vaccine, and the dates. Diabetes Self-Management Action Plan includes signs and symptoms, I will do and I will consider sections; the cause of hyperglycemia, hypoglycemia, and sick day rules.

APPENDIX A

Appendix A contains the following "R" forms (authorized for local reproduction).

MEDCOM Form 705-R (Diabetes Visit)

MEDCOM Form 706-R (Diabetes Flow Sheet)

MEDCOM Form 724-R (Diabetes Action Plan)

☐ INITIAL VISIT
☐ FOLLOW-UP VISIT

MEDICAL RECORD - DIABETES VISIT

For use of this form see MEDCOM Circular 40-8

DATE:
TIME:

SECTION I - PATIENT VITAL SIGNS *(Completed by Health Care Personnel)*

AGE: _____ TEMP: _____ RESP: _____ PULSE: _____ HT: _____ WT: _____ BMI: _____

GENDER: ☐ Male ☐ Female ALLERGY: _____

Do you use tobacco?	☐ Yes ☐ No	Do you have pain?	☐ Yes ☐ No	
Want to quit?	☐ Yes ☐ No	Location:		
Tobacco cessation materials offered?	☐ Yes ☐ No	Intensity: _____ /10 (0 = no pain - 10 = worst pain		Initials of Staff
Have you or family member recently been deploy?	☐ Yes ☐ No			
Do you believe your symptoms are deployment related?	☐ Yes ☐ No			

SECTION II - PATIENT DEMOGRAPHICS (SUBJECTIVE) *(Filled Out by Patient)*

SINCE YOUR LAST PLANNED DIABETES VISIT HAVE YOU HAD:	YES	NO		YES	NO
1. A diabetes-related ER or hospital visit.			6. Weight loss or gain of more than 10 pounds in last 6 months?		
2. Excessive thirst, hunger, urination or blurred vision or did you have episodes of blood sugar >180-200?			7. Change or loss of vision? Date of eye exam? _____		
3. Shakiness, rapid heart, confusion, night sweats or hadache or did you have episodes of blood sugar <70?			8. Skin problems or rashes?		
4. Feet numbness, tingling, burning or cold sensation?			9. Female patients - Are you planning a pregnancy now or in the future?		
5. Have you ever had a foot ulcer? Date of foot exam? _____			10. Are you feeling overwhelmed by your diabetes?		

11. Which food affects your blood glucose the most? ☐ Chicken breast ☐ Salad ☐ Rice or potato ☐ Cheese ☐ Other _____ ☐ Don't know

12. List all "over the counter" medicines, vitamins, herbals and supplements.

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Completed by Health Care Provider)

PART A - PROBLEM LIST (SUBJECTIVE)

ETOH: ☐ Yes ☐ No ☐ Cut down ☐ Annoyed ☐ Guilty ☐ Eye opener

During the past month have you been bothered by feeling: ☐ Down, depressed, or hopeless ☐ Little interest or pleasure in doing things

Home blood glucose monitoring asessed? ☐ Yes ☐ No Results: _____

Medication list reviewed? ☐ Yes ☐ No

ADDITIONAL HISTORY:

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
(Patient's Signature)

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Cont)

COMMENTS/ADDITIONAL HISTORY:

PART B - PHYSICAL EXAM (OBJECTIVE)

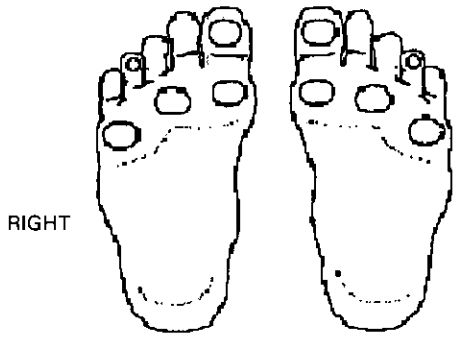
PHYSICAL EXAM *(Record significant findings below)*

FOOT EXAM: NOT ASSESSED = NA

A. PEDAL PULSES	☐ YES	☐ NO	☐ NA
B. NAILS TOO THICK OR LONG	☐ YES	☐ NO	☐ NA
C. FOOT ABNORMAL SHAPE	☐ YES	☐ NO	☐ NA
D. VIBRATORY SENSE INTACT	☐ YES	☐ NO	☐ NA

DRAW/LABEL FINDINGS

C = Callous, U = Ulcer, M = Maceration, R = Redness, S = Swelling



Lab results in CHCS ☐ YES ☐ NO

MONOFILAMENT EXAM (Draw in circle):
+ = Positive sensation - = Negative sensation

PART C - DIAGNOSIS (ASSESSMENT)

☐ TYPE 1 DM ☐ TYPE 2 DM ☐ ADEQUATE CONTROL - NO CHANGE IN TREATMENT ☐ INADEQUATE CONTROL

WITH:

1. DYSLIPIDEMIA	☐ YES	☐ NO	4. NEUROPATHY	☐ YES	☐ NO
2. HYPERTENSION	☐ YES	☐ NO	5. RETINOPATHY	☐ YES	☐ NO
3. NEPHROPATHY	☐ YES	☐ NO	6. _____	☐ YES	☐ NO

PART D - TREATMENT PLAN (PLAN)

RECOMMEND:

☐ ASA 325 mg ☐ ANNUAL FLU ☐ PNEUMONIA VACCINE ☐ ACE INHIBITOR *(Name&Dose)*: _____

LABS: ☐ HbA1C ☐ LIPIDS ☐ MICRO A/CR RATIO ☐ TSH ☐ CHEM 7 ☐ OTHER: _____

☐ DIABETIC ACTION PLAN REVIEWED AND GIVEN TO PATIENT

PART E - REFERRALS

☐ A. DM PATIENT EDUCATION/ CASE MANAGEMENT	☐ D. NUTRITION THERAPY	☐ H. OTHER
	☐ E. OPHTHALMOLOGY/OPTOMETRY	_____
☐ B. ENDOCRINOLOGY	☐ F. PODIATRY	_____
☐ C. NEPHROLOGY	☐ G. TOBACCO CESSATION PROGRAM	_____

PART F - FOLLOW-UP APPOINTMENT

☐ 1 MONTH ☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ OTHER: _____

_____ _____

(Provider's Name) *(Provider's Signature)*

MEDICAL RECORD - DIABETES FLOW SHEET

For use of this form see MEDCOM Circular 40-8

1. PRIMARY PROVIDER: _____

2. DIAGNOSIS: ☐ TYPE 1 DM ☐ TYPE 2 DM DATE OF ONSET: _____

WITH: ☐ HTN _____ ☐ CAD _____ ☐ PVD _____ ☐ DYSLIPIDEMIA _____

☐ NEUROPATHY _____ ☐ RETINOPATHY _____ ☐ NEPHROPATHY _____

☐ PSYCHOSOCIAL _____ ☐ OTHER _____ ☐ OTHER _____

3. DATE OF INITIAL DIABETIC EDUCATION: _____

DATE OF VISIT (*Month & Year*):								
4. MONITORED ITEM	**DQIP TARGET**	**PT GOAL**	**TEST RESULTS**					
a. BMI								
b. BP	% <140/90							
c. HbA1C	> 9.5							
d. LDL	% <130							
e. Micro Alb	% Assessed							
f. Serum CR	% Assessed							
g. Dilated Eye Exam	% Assessed							
h. Foot Exam	% Assessed							
i. Education Update								
j.								
5. REFERRALS								
a. DIABETES EDUCATION/CASE MANAGEMENT								
b. ENDOCRINOLOGY								
c. NEPHROLOGY								
d. NUTRITION THERAPY								
e. OPHTHALMOLOGY/OPTOMETRY								
f. PODIATRY								
g. TOBACCO CESSATION								
h.								
i.								
6. PCM CONSIDERATIONS								
a. ACE INHIBITORS								
b. ASA q DAY								
c. ANNUAL FLU VACCINE								
d. PNEUMONIA VACCINE								
PROVIDER INITIALS:								

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

DIABETES ACTION PLAN

For use of this form see MEDCOM Circular 40-8

SECTION I - MY DIABETES SELF-MANAGEMENT GOALS

1. SMALL STEPS FOR CHANGE - SELECT AND INITIAL 3 GOALS FROM THE LIST BELOW

(INITIALS) **I WILL:**

_____ Monitor my blood sugar _____ times per day, _____ times per week.
_____ Record my blood sugar in a record book.
_____ Bring my blood glucose meter to every visit.
_____ Eat meals and snacks at designated times.
_____ Use carbohydrate counting to plan my meals.
_____ Read labels for carbohydrate and fat content.
_____ Control my portion sizes.
_____ Build more activity into my day *(by walking, parking further away, taking the stairs)*:

_____

_____ Enroll in a smoking cessation program.
_____ Monitor my blood pressure _____ times per _____
_____ Wash, dry, and examine my feet daily.

2. MEDICATION LIST

I will become familiar with and take the following medications as directed by my health care provider:

3. MY PERSONAL BEST

DIABETES	MONITORS FOR	ACCEPTABLE RANGE	MY RANGE	GOAL FOR NEXT VISIT(S) Date:	Date:
BMI	Body weight				
Blood pressure	Work of the heart				
HbA1c	Average 3 month blood sugar				
LDL (lipid)	Heart disease				
Urine Protein	Kidney disease				

SECTION II - MY DIABETES SELF-MANAGEMENT FOLLOW-UP PLAN

I WILL HAVE AN:	DATE	DATE	DATE	DATE
Annual eye exam				
Annual foot assessment				
Annual flu vaccine				
Pneumonia vaccine				

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
(Date Signed)

_____
(Patient's Signature)

_____
(Provider's Signature)

DIABETES SELF MANAGEMENT ACTION PLAN

1. HYPERGLYCEMIA - If I recognize signs/symptoms of hyperglycemia:

- Fatigue
- Excessive thirst
- Frequent urination
- Blurred vision

I will:

- Drink plenty of non-caloric fluids
- Check my blood sugar and ketones
- Adjust my meal plan and activity level
- I will call my primary care provider if my blood sugar is > _____ *(default value is 250)* three times in a row within _____ hours

And I will consider the cause:

- Forgetting to take diabetes medication
- Overeating
- Infection/Illness
- Stress
- Inactivity

2. HYPOGLYCEMIA - If I recognize signs/symptoms of hypoglycemia:

- Weakness
- Rapid heart beat
- Light-headedness or confusion
- Shakiness
- Sweating

I will:

- Eat a snack containing fast-acting carbohydrates (*e.g., juice, cola, skim milk, crackers*)
- Re-check blood sugar in 15 minutes; if < _____ , eat an additional fast-acting carbohydrate
- Eat a meal or snack within 30 minutes

And I will consider the cause:

- Delaying meals
- Not eating enough food
- Too much diabetes medication
- Too much exercise

3. SICK DAY RULE - When I am sick:

I will:

- Continue to take my diabetes medication
- Monitor my blood sugar every _____ hours and if > _____ test for ketones
- Eat the usual amount of meals and snacks divided into smaller proportions
- Drink fluids frequently (*8 ounces per hour while awake*)

And I will seek medical assistance if I have:

- Blood sugar > _____ or double the range set by my health care provider
- Blood sugar < _____ that does not improve after eating a meal or snack
- Fever of 101 degrees or higher
- Nausea and vomiting, especially if no food or fluid intake for more than 5 hours
- Symptoms of shakiness, lightheadedness, sweating, rapid heart rate that does not improve after eating a meal or snack
- Any problems with my feet (*burns, blisters, swelling, bruising or discoloration, bleeding, or oozing of fluid*)

_____ *(Patient's Signature)*

_____ *(Date Signed)*

_____ *(Provider's Signature)*

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6026.

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